ALASKA MEDICAID
PHARMACY AND THERAPEUTICS COMMITTEE

Location of Meeting
Frontier Building, 3601 C Street, Room 880-890

MINUTES OF
February 13, 2004
8:00 a.m.
Final approved on March 19, 2004

Committee Members Present:
Alexander H. vonHafften
Arthur S. Hansen
Terry K. Babb
Michael Boothe
Heidi Brainerd
Richard E. Brodsky
Kelly C. Conright (telephonic)
Charlene M. Hampton
Thomas C. Hunt (late arrival)
Ronald J. Miller
Richard C. Reem
Sherrie D. Richey (late arrival)
Janice L. Stables
George Stransky
Trish D. White (late arrival)

Committee Members Absent:
Gregory R. Polston
Robert H. Carlson
Traci Gale
Nathaniel Haddock
R. Duane Hopson
Diane Liljegren
Michael C. Norman

Others Present
Dave Campana
Sandy Kapur

I. CALL TO ORDER:

Chairman Brodsky called the meeting to order at 8:00 a.m.

II. ROLL CALL:

The roll call was taken and a quorum was present after a short delay with the above noted members.

Chairman Brodsky noted that Robert Skala, George Rhyneer and John Duddy resigned from the P&T Committee. Thomas Hunt and Sherrie Richey were appointed to the committee as replacements.

David Campana gave an overview of the PDL process. The committee was developing a preferred drug list, not a formulary. All Medicaid drugs previously covered were still available by the physician

marking on the prescription the medical necessity of the non-preferred drug as long and the patient meeting the criteria. If the patient is allergic to the preferred drug, has toxic side effects or drug interactions or if there are special indications on the non-preferred drug then the physician can prescribe the non-preferred drug. The procedure list for the P&T Committee has been developed and distributed to the members. The website has been redesigned to make things easier to find. The procedure list and the total preferred drug list will be added to the website. We had planned on implementing soft edits on February 4, 2003, but that has been pushed back due to concerns that not all providers were notified. The website indicates that the soft edits would be effective March 4, 2003, but that will be further delayed. Once the preferred drug list is implemented, it would be rolled out in sections with one section coming out for soft edits each month. Sixty days after the soft edits begin, the hard edits will be enacted for a phase-in period of about 90 days.

In response to Kelly Conright, David Campana said the provider community felt a criteria should be introduced that said if the preferred medication was ineffective or failed for a patient then a non-preferred medication could be prescribed.

In response to Alexander vonHafften, David Campana said prior authorization was one of the avenues that could be used for implementing the preferred drug list. Prior authorizations require more administrative effort for the prescriber, so we decided to implement a process of noting medical necessity for non-preferred drugs. If there are multiple drugs on the preferred drug list, the provider would only need to note an allergy to one of the preferred drugs to prescribe a non-preferred drug.

Chairman Brodsky questioned why it was only necessary to indicate an allergy to one of the preferred drugs in order to prescribe a non-preferred drug. He felt the physician should be encouraged to prescribe one of the other preferred drugs before going to a non-preferred drug.

David Campana said the criteria for prescribing non-preferred drugs would be left up to the P&T Committee. The physician could write on the prescription that the patient was allergic to all preferred drugs before prescribing a non-preferred drug.

Heidi Brainerd pointed out that a patient might be allergic to a specific component in a drug, so it would be important to identify the component they were allergic to before prescribing another drug.

Kelly Conright (indiscernible -- telephonic and away from microphone).

III. PUBLIC COMMENTS:

Jeff Goodgame discussed Zithromax. Jeff Goodgame was a physician with U.S. Medical and Pfizer as well as a board certified family physician in Florida for 15 years. He participated in, and was a principal investigator, in over 120 clinical research trials with various drug companies. Zithromax was approved in 1992 in the United States. Zithromax has fewer G.I. side effects that azithromycin or other macrolides. Zithromax probably has better compliance due to the dosing regimens. Zithromax also has an expanded spectrum of anti-macrobial activity including the A-typical mycoplasma pneumonia and chlamydia pneumonia. It also has remained effective in many disease states despite macrolides resistance in a community. In e-flux we tend to have significant tissue levels above the MICs that serum levels or laboratory levels cannot reflect. Clinically, we do much better than any laboratory would ever find in a community, because of our high MICs and the high tissue levels. Zithromax has fewer drug interactions than the other macrolides, because of its pathway outside of the sideachrom P450, which is

critical to the COPD group, the elderly and the complex HIV patients. Zithromax has unique pharmacokinetics that allow a five-day, three-day or single dose therapy. Zithromax can also be given in a pregnancy category B status. Zithromax formulations are fairly flexible in that we have the pediatric oral suspensions, sachets, IV formulations and tablets. Financially, both the macrolide tablets and suspensions were reviewed in the 2003 Alaska State Drug Utilization Data. Pfizer reviewed this information and found Zithromax to be less expensive and more cost effective to Alaska Medicaid than clarithromycin in both formulations, for each disease state and in the adult and pediatric population. Zithromax has unique indications from other macrolides in that we have a STD indication for pid, cervicitis, chlamydia trachomatis, gonorrhea, etcetera. We also are in the guidelines in the pneumonia arena both from the CDC Strep Pneumonia Working Group for drug resistance strep pneumonia, ATS Guidelines in 2001, IDSA in 2000 and 2003 included the macrolides as initial therapy in immunocompromised patients. In acute exacerbation of chronic bronchitis, a single dose was comparable both clinically and in bacterial efficacy. In tonsillitis, we actually showed superior data over penicillin both in clinical and bacterial efficacy. We have recently acquired the FDA indication for acute bacterial sinusitis.

In response to Chairman Brodsky, Jeff Goodgame said Zithromax was in the guidelines for pneumonia and for patients over 60 years of age there may be improved survival when Zithromax is included in the regimen.

John Bocachica said he was the chief of dermatology at the Alaska Native Medical Center in Anchorage. He discussed the oral antifungals and oral anti-viral agents available. The two oral antifungals agents that appear to be effective are sporanox and lamisil. There seems to be an under recognition of the need to treat onychomycosis. People with diabetes are nearly three times as likely to have onychomycosis as non-diabetics. Inactive onychomycosis infection can lead to secondary bacterial infection, ulcerations and even opthalmalysis, which can possibly lead to gangrene and amputations. Diabetic neuropathy impairs perception of repetitious trauma of the nails. Diabetes reduces the immune system's ability to fight infection. And we know that impairments vascular circulation and diabetes, which reduces the ability to heal, the risk of severe infection is greater in patients with diabetes and onychomycosis than in those without onychomycosis. The pain alone is quite a debilitating association with onychomycosis to the point where patients cannot participate in normal activities, physical therapy and basic lift functions. Nails affected with onychomycosis can in turn become even more painful if not treated. Onychomycosis increases the potential for secondary bacterial infection in patients with diabetes and immunocompromised patients. Both sporanox and lamisil are very good medications for the treatment of fungal infections in an oral fashion. My choice for inclusion in the formulary would be lamisil, because sporanox utilizes the P450 cytochrome enzymatic system. The target population that we tend to treat with onychomycosis tends to be the older population. Almost 40% of these elderly people are on other medications that use the same P450 cytochrome enzymatic system so the use of sporanox and the other agents has a potential for drug interaction and adverse effects. To date, lamisil has not shown any significant drug interactions, because it does not use the P450 cytochrome enzymatic system. Several studies indicate that only 5.3% of patients stopped using lamisil because of negative effects. Sporanox has been shown to be associated with cardiac adverse effects, which lamisil has not been shown to have. He felt lamisil should be the medication of choice for the preferred drug list, which is the medication of choice nationwide.

Bill Lucht said he was a critical care and pulmonary specialist in Anchorage with 10-15% of his patients being Medicaid patients. He recalled the time before azithromycin was available and the issues with erythromycin and biaxin, which were effective medications in some settings, but were associated with

many compliance problems and G.I. upset intolerance issues. The addition of azithromycin has made a major difference in patient tolerability issues. He reviewed some of the other instances where he utilized macrolides. The second topic he addressed was the use of long-acting brocodialator medications. He has spoken on behalf of Advair on a couple of occasions. The medications have been indicated both in asthma and chronic obstructive lung disease. He was convinced that the data was very clear that the usage of these medications significantly improved performance on the part of the patient and their quality of life. More recently in the area of COPD it has been suggested that they are beneficial in decreasing the risk of recurrent episodes of bacterial bronchitis with associated morbidity, mortality and associated expense. It was difficult to determine which medication he preferred in the classification. If you look at the dilators by themselves, they each have advantages and disadvantages, which he discussed. He did not feel any particular medication addressed a total category of patients and both drugs were beneficial in a given situation.

Chipp Leibach, a respiratory representative with Glaxo SmithKline, discussed the long-acting beta-agonists. There are no head-to-head studies between salmeterol and formoterol, so we need to review the package insert. When we do that, we find that they are both indicated for maintenance therapy for asthma and COPD. They are both indicated for exercise induced bronchospasm. The dosing and safety profiles are similar. However, there is one glaring and significant difference between serevent discus and foradil aerolizer, which is the delivery device of the medication. Serevent diskus is considered the Cadillac of delivery devices, because it is simple, self-contained, you only get one dose, it is easy to use and the counter provides immediate feedback. Someone with a 70% loss of lung function can get enough flow out of the diskus to get the required medication. As we travel around the state looking at other formularies of long-acting beta 2 agonists, you will find that serevent is on all major formularies, including the Alaska Native Medical Center, Providence Hospital, Regional Hospital and various others.

Tracey Bethard, Glaxo SmithKline, spoke on behalf of several of her customers that wanted to insure that valtrex was added to the preferred drug list. She provided letters from three providers in the community expressing the desire to have valtrex added to the preferred drug list. The antiviral medications were pretty much equivalent, but valtrex has the indication to reduce the transmission of genital herpes between partners. It is also the only antiviral patients can take on a QD dosing regimen.

Eric Remestand, Schernig Pharmaceuticals, discussed the differences between foradil and salmeterol. Foradil is an empathetic molecule, which means it is both hydrophilic and lipophilic. It provides the onset of albuterol and within five minutes you have bronchodilation and a long acting duration lasting up to 12 hours. Salmeterol is strictly a lipophilic molecule, which provides moderate onset within 15 to 20 minutes and a long duration lasting up to 12 hours. Indications are for exercise induced bronchospasm. We have been indicated down to the age of five years. Salmeterol should be used 30 minutes prior to exercise whereas foradil can be used 15 minutes prior to any type of exercise. Maintenance is the third indication and the fourth indication is the use in chronic obstructive pulmonary disease, including patients with emphysema and chronic bronchitis. A parallel group study of formoterol and salmeterol showed that the PEF, after five minutes, the dosing was significantly greater in the foradil arm, which was 393 liters per minute versus 371 liters per minute, statistically significant at 0.001. Albuterol was used less as a rescue medication in the foradil arm. The foradil patients experienced more episode free days. Dr. Brodsky did a study on exercise induced bronchospasm. He looked at foradil at 12 micrograms and albuterol at 180 micrograms looking at the FEV1 percentage reduction of less than 20 percent. He found that foradil provided a mean expiatory FEV1 decrease of 15 minutes at 4 hours, 8 hours and 12 hours along all times points, which was statistically significant and lasted beyond the 12 hour period. Dr. Ecotokiss (ph) did a study on COPD looking at foradil 12 and 24

micrograms versus salmeterol 50 and 100 micrograms in a double dummy placebo study. He found that foradil statistically was greater than salmeterol as defined in a 51% change in the FEV1 AUC over a 24 hour period. In a study done by Dr. Ron Atall (ph) looked at the devices we have available. The number one device for delivery and deposition into the lungs is any molecule less than 5 microns. The turbohaler provided us with superiority. The number two is the aerolizer, which is used by foradil as it fits between the teeth and it allows the drug to be directly deposited into the trachea and deeper deposition into the lungs. The diskus is blocked by the teeth and provides a V-shaped distribution of the product into the oral cavity and preventing as large of a quantity of molecule deposit into the lower parts of the lungs. In terms of the device itself, the capsule provides dose confirmation as the patient can open up the inhaler and look to see if the medication is completed. If it is not then he can re-inhale the medication. The medication is also dispensed in foil packets so you can control the dose. You can give one dose to the child, parent or grandparent and you are guaranteed it is a single dose. With the diskus there is an opportunity to click several times and get several doses during the day. If a diskus is dropped, you have the possibility of losing the doses that are on the dispensing wheel. The recent SMART Trial provided data and a black box warning to salmeterol. The study showed a placebo and salmeterol containing arm in which there was a significantly higher percentage of asthma related deaths in the African-American population of 13 out of 13,174 verses 4 out of 13,179 at 24 weeks. This study was halted. Combination products provide less flexibility in dosing of the individual agents. There could be mistaken distribution of the strengths. There are only three strengths, 125, 250 and 500. There is no flexibility for average dosing of the steroids themselves.

Greg Transue, a registered respiratory therapist, discussed delivery devices. He works with chronic obstructive pulmonary disease patients on a regular basis. Some of his older patients have difficulties in figuring out how to use the aerolyzers, which has 15 to 16 steps versus 3 or 4 steps for the diskus. He did not feel his patients received significant benefits from the aerolyzers, because they were so difficult to use.

IV. REVIEW OF MEETING MINUTES

Chairman Brodsky asked the board members to review the meeting minutes of October 10, 2003, November 21, 2003 and January 16, 2004.

RONALD MILLER MOVED TO APPROVE THE MINUTES OF OCTOBER 10, 2003.

Alexander vonHafften referenced page 4 of the October 10, 2003 meeting minutes where a question was asked about the PDL going out for an annual bid on the drugs and the answer indicated that would be up to the committee to decide. He questioned if that was correct.

David Campana said that was incorrect. We are part of a PDL pool arrangement with other states, which will solicit bids for drugs on an annual basis.

Alexander vonHafften referenced page 3 of the October 10, 2003 meeting minutes. Someone asked if the usage of limited drugs had been compared to the cost of hospitalization in the past. The speaker said "that using a particular drug decreased drug costs, but increased hospital doctor care. The answer indicated that Michigan had analyzed this, but had not found even temporal results. That would be saying that the P&T Committee failed in their duty to provide equivalent drugs". One of the main concerns about PDLs is the possibility of cost shifting. Dr. vonHafften felt that was an interesting statement and wanted to make sure all the board members noted it in their review.

David Campana said that was taken from the questions during the public comment period.

Chairman Brodsky pointed out that they did not know who made the comment or answered the question. It would be helpful in future meetings if the speakers were identified more clearly.

RONALD MILLER MOVED TO ACCEPT THE MINUTES OF OCTOBER 10, 2003 AS AMENDED. SECONDED BY ALEXANDER vonHAFFTEN. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Miller, Reem, Stables, Stransky, vonHafften.

NAY: None.

Chairman Brodsky asked for comments and questions to the meeting minutes of November 21, 2003.

David Campana noted that Dr. Carlson was not on teleconference at that meeting. Chairman Brodsky said that would be reflected in the corrections.

Terry Babb referenced page 9, the fourth paragraph, where it said "took Captopril every 3 hours" and should read "took Captopril every 8 hours."

Heidi Brainerd referenced page 16 where Richard Brodsky moved that all the PPIs were interchangeable and equivalent. She had been the unidentified female that opposed the vote due to pediatric indications.

Alexander vonHafften referenced page 14 after the motion regarding ACE Inhibitors where there was a discussion regarding generics, Altace and some other recommendations. He questioned if that conversation had ever been finished.

David Campana did not believe they had finished the conversation. When they developed the list they were unsure of First Health's recommendations.

Sandy Kapur said they were not sure if the vote was to have Altace, plus the three available generics, as preferred or to have Altace, the generics, plus the First Health recommended agents as preferred.

Terry Babb thought there was some discussion that Sandy Kapur or someone else from First Health was going to look at the potential impacts of including the branded Altace product, but they never returned to the discussion.

David Campana said they discussed the issue at the next meeting and determined that the committee only wanted to look at clinical aspects and not financial aspects. He felt the committee needed to go back and confirm what they wanted on the ACE Inhibitors. Currently they had the generic drugs and Altace. They had not included the other drugs that First Health had recommended. The question was whether or not they wanted to make mavik, aceon, lotensin and univasc preferred drugs.

Sandy Kapur said it was announced yesterday by the FDA that lotensin has gone generic.

Chairman Brodsky pointed out that they were discussing the meeting minutes and further actions should be addressed later in the meeting.

Alexander vonHafften said they wanted to make the best clinical decisions. However, having the guidance to insure that the best clinical decision was also the best economical decision was the best way to go. If including more medications accomplished the economic issue, we should be open to that without letting economics drive the decision making.

GEORGE STRANSKY MOVED THAT THE MINUTES OF NOVEMBER 21, 2003 BE APPROVED AS AMENDED. SECONDED BY ALEXANDER vonHAFFTEN. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Miller, Reem, Stables, Stransky, vonHafften.

NAY: None.

David Campana suggested reviewing the January 16, 2004 meeting minutes at the next meeting once everyone had an opportunity to review them.

V. HERPETIC ANTIVIRALS - Antiviral for herpes viral infection

Sandy Kapur said they would not be reviewing the B and C agents and those would have open access as always. She reviewed the three agents in the antiherpes virus class. Zovirax is available as the generic acyclovir in tablets, capsules and suspension. Valtrex is available brand name only and is converted to valacyclovir in the gut. Famvir is very similar to acyclovir, but there is another hydroxyl moiety added to it, which is converted to penciclovir in the gut. Acyclovir and famvir have comparable efficacy for treatment of recurrent herpes simplex infections in HIV patients and immunocompromised patients, the treatment of herpes zoster in immunocompromised patients and immunocompetent patients. Valtrex most recently received the FDA approval to have the FDA labeled indication to reduce the risk of heterosexual transmission of genital herpes to susceptible partners when used with safe sex practices. Valtrex and acyclovir have a slight difference in that they have been studied and used more often and extensively in the treatment of CMV in organ transplant patients. Acyclovir is the only agent that has pediatric and adult indications for treatment of chickenpox. Valtrex and famvir have similar indications with the exception of that one recently FDA labeled indication for the decrease in heterosexual transmission of genital herpes. We contacted Dr. Burger for his recommendations, but we are still waiting for them.

In response to Janice Stables, Sandy Kapur said she received the e-mail from Dr. Burger in which he commented on several classifications, but he did not comment on antiviral agents.

George Stransky said when all the drugs appear in the body, they have to be triple phosphorylated. The first phosphorylation selectively conducted by the viral DNA over the cellular DNA in a 200-to-1 ratio provided a lot of safety as an antiviral.

Chairman Brodsky said acyclovir would be included on the preferred drug list as a generic due to its particular indication for pediatric use, even though it has to be given multiple times to treat an infection

and is not as convenient as the other drugs. The real question is valtrex versus famvir, which are both easier to use than acyclovir.

Sandy Kapur said valtrex has been studied more extensively in the treatment of CMV.

Chairman Brodsky said Dr. Bochacheeka (ph) felt both valtrex and famvir were good drugs, but valtrex was simple and convenient.

Sandy Kapur said the recommendation from First Health was to include the generic acyclovir, valtrex and famvir.

ALEXANDER vonHAFFTEN MOVED TO ACCEPT ACYCLOVIR, VALTREX AND FAMVIR. SECONDED BY RONALD MILLER. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Miller, Reem, Stables, Stransky, vonHafften.

NAY: None.

Chairman Brodsky noted that Trish White and the two new members, Sherri Richey and Tom Hunt, had arrived at the meeting. The committee took a break from 9:25 a.m. to 9:43 a.m.

VI. MACROLIDES - ANTIBIOTIC

Sandy Kapur reviewed the macrolides. Erythromycin is available generically in base, estolate, stearate and ethylsuccinate formulations. Biaxin and biaxin XL are available brand name only. Zithromax is available brand name only as tablets, capsules and oral suspensions. Dynabac (dirithromycin) is the fourth macrolide that not much is heard about. These agents have excellent activity against the a-typical bacteria of mycoplasma, chlamydia and legionella. Erythromycin has much greater positive activity and lesser activity gram-negatives than the advanced macrolides such as biaxin and zithromax. Dynabac has very poor activity against H flu. We spoke to an ID specialist, a pediatrician and a pulmonologist. The three specialists felt that zithromax and biaxin were clinically equivalent, but due to the greater ease and tolerance of zithromax, the ID specialist preferred zithromax. The pediatrician and the pulmonologist had a hard time differentiating between the three products and they had no experience at all with dynabac. They felt erythromycin, zithromax and biaxin were each unique and requested that all three agents be placed on the preferred drug list.

In response to Richard Reem, Sandy Kapur said they had data on utilization, but they preferred not to disclose it because it was not reflective of class equivalency.

In response to Chairman Brodsky, Sandy Kapur said the specialists preferred erythromycin, azithromycin and clarithromycin. They had no feelings whatsoever about dynabac.

ALEXANDER vonHAFFTEN MOVED THAT ERYTHROMYCIN, AZITHROMYCIN AND CLARITHROMYCIN BE PLACED ON THE PREFERRED DRUG LIST. SECONDED BY RICHARD REEM. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Hunt, Miller, Reem, Richey, Stables, Stransky, vonHafften, White.

NAY: None.

VII. SECOND-GENERATION CEPHALOSPORINS - ANTIBIOTICS THIRD-GENERATION CEPHALOSPORINS - ANTIBIOTICS

Sandy Kapur reviewed the four agents within the second-generation cephalosporins. Ceclor and ceclor CD is available generically as capsules and oral suspension. Cefzil is available brand name only as tablets and oral suspension. Ceftin is available generically as tablets, but brand name only as oral suspension. Lorabid is available brand name only as capsules and oral suspension. As a class, the penicillins and the cephalosporins interfere with cell wall synthesis and are inherently resistant to beta-lactam producing organisms. The second-generation cephalosporins have greater gram-positive activity, but not as great as the first-generation. Palatability is important for children and pediatrics. Ceclor and lorabid appear to be the most palatable of the oral suspensions, but they also appear to be the least potent agents in this class. Ceftin appears to be the most potent agent in the class, but it appears to be the most unpalatable as an oral suspension and is often discontinued in the pediatric population. Cefzil is considered intermediate in its potency and taste. The CDC working group concluded that amoxicillin should remain the first line antimicrobial for treating acute otitis media, followed by high doses of amoxicillin/clavulanate; cefuroxime acetyl or intramuscular ceftriaxone. Children allergic to or intolerant to amoxicillin or other beta-lactam antibiotics should use clarithromycin or azithromycin. The American Thoracic Society Guidelines for management of community acquired pneumonia in adults stated that certain agents should not be used if streptococcus pneumonia is suspected. The agents they said should be avoided are ceclor and lorabid, because they are considered less potent. The Infectious Disease Society of American updated their guidelines for initial therapy of community acquired pneumonia in December of 2003 and recommended a high dose of amoxicillin, as well as cefzil, ceftin and an advanced macrolide as a first line therapy for suspected community acquired pneumonia. We contacted an ID specialist and he had no opinion whatsoever. He said the rest of the oral cephalosporins were fairly clinically equivalent and cost should drive the choice. The pediatrician and pulmonary specialist had no strong feelings about lorabid or ceclor, but they preferred either ceftin or cefzil. The pediatrician was very much in favor of ceftin being the preferred agent over cefzil according to the CDC Guidelines.

Alexander vonHafften asked if the specialists consulted were from Alaska. He also asked that the name of the specialists be included in the record in the future.

David Campana said Dr. Burger is the infectious disease specialist, Dr. Dion Roberts is the pediatrician and Dr. Thad Woodard is the pulmonologist.

Richard Reem said ceclor had many skin problems and side effects that he would prefer not to deal with.

TERRY BABB MOVED TO INCLUDE CEFPROZIL (CEFZIL) AND CEFUROXIME (CEFTIN) OF THE SECOND-GENERATION CEPHALOSPORINS TO THE PREFERRED DRUG LIST. SECONDED BY JANICE STABLES. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Hunt, Miller, Reem, Richey, Stables, Stransky, vonHafften, White.

NAY: None.

Sandy Kapur reviewed the third generation cephalosporins. Omnicef is available brand name in capsules and suspension. Vantin is available in capsules and suspension. Cedax is available in capsules and suspension. Spectracef is available as a tablet only. Suprax is no longer being made. Omnicef is a strawberry tasting suspension that appears to be very palatable for children. Vantin is a lemon cream suspension that appears to be very gritty and unpalatable for children. Cedax is in a cherry flavor and did not have a pediatric rating for taste. Spectracef is not available in a suspension. In regards to efficacy, the third-generation cephalosporins inhibit bacterial cell wall synthesis just as the penicillins and first- and second-generation cephalosporins. Omnicef and cedax may be dosed once or twice daily. Vantin is dosed twice daily. They have excellent gram-negative activity and less gram-positive activity. They are excellent against H flu. In terms of efficacy against strep pneumonia, it appears that cedax is a little less effective when compared to vantin and omnicef. Our ID specialist stated that the oral cephalosporins were fairly equivalent and cost should drive the choice. The pediatrician stated that omnicef was one of the more palatable agents, but he did not have a frame of reference for cedax or spectracef. The pulmonary specialist considered these agents clinically equivalent and used whatever was on the formulary at his practicing facility.

Richard Reem noted that it was not easy to get children to take vantin.

Janice Stables said something that could be dosed once a day was greatly appreciated.

In response to Thomas Hunt, Chairman Brodsky said the committee would only be reviewing oral agents. They would not consider IV therapy or other classes.

Terry Babb felt that since the specialists agreed that the agents were clinically equivalent and omnicef had a nice schedule and was palatable then it would be logical to make it a preferred agent.

TERRY BABB MOVED THAT OMNICEF, VANTIN, CEDAX AND SPECTRACEF WERE CLINICALLY EQUALIVENT BASED ON EFFICACY. SECONDED BY ARTHUR HANSEN.

Sherrie Richey noted that the agents may be clinically equivalent based on efficacy, but from a practical standpoint there was a difference if you had a hard time getting the children to take the medication or you considered the dosing issues.

Terry Babb withdrew his motion so palatability and dosing schedules could be addressed.

JANICE STABLES MOVED TO ADD OMNICEF TO THE PREFERRED DRUG LIST AND ANY OTHER THIRD-GENERATION CEPHALOSPORIN DRUGS THAT WERE REASONABLY PRICED. SECONDED BY RICHARD REEM. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Hunt, Miller, Reem, Richey, Stables, Stransky, vonHafften, White.

NAY: None.

Sandy Kapur said First Health's recommendation was to include omnicef and cedax to the preferred drug list.

VIII. ONYCHOMYCOSIS ANTIFUNGALS - ANTIGUNAL

Sandy Kapur reviewed the onychomycosis antifungals. They were only dealing with the agents that had the FDA labeling for the treatment of onychomycosis, which were griseofulvin, sporanox and lamisil. Griseofulvin is available only as the brand name product. Lamisil is available only as the brand name 250-milligram capsule. Sporanox is available as capsules and oral suspension, but the oral suspension was not approved for onychomycosis. Sporanox can be used for invasive fungal infections. For anything other than onychomycosis, sporanox would be approved even if it were not chosen as a preferred agent. In September of 2002 the FDA put out an advisory that sporanox should not be used to treat onychomycosis in patients with ventricular dysfunction or a history of congestive heart failure. Also in that FDA labeling of September 2002, the risk of padotoxicity was mentioned for both sporanox and lamisil such that both products had their FDA approved labeling changed.

In response to George Stransky, Sandy Kapur said in nail bed concentrations, lamisil achieves much higher concentrations such that it is sidle in the nail bed onychomycosis. Sporanox is not able to achieve such high concentrations in the nail beds and is static. The LION study was the largest study for the treatment of toenail onychomycosis. The efficacy of lamisil and sporanox were compared in patients with mild to moderate onychomycosis. After 72 weeks of follow-up, 75-80% of the lamisil patients were concerned cured and 38-49% of the sporanox patients were considered cured. They also did a five-year follow-up and 46% of the lamisil patients were disease free and only 13% of the sporanox patients were considered disease free. The study determined that lamisil was more effective than sporanox in the treatment of onychomycosis. Drug interaction wise, rifampin can increase the clearance of lamisil. Tagament can decrease the clearance of lamisil. There are significant drug interactions with sporanox. There are studies of the oral agents being used in combination with the topical antifungals. An ongoing study that has not been published is on the sequential therapy of lamisil and sporanox, but not concurrently. They both inhibit the synthesis of (indiscernible), but at different parts in the pathway. Our specialists had no preferences. The pediatrician agreed that griseofulvin was an effective, important treatment and the treatment of choice in pediatric patients for ringworm, infections of the skin, and hair and nails and should be available as an option. The ID specialist had a preference for lamisil due to safety issues. He noted the FDA advisory, but he felt that sporanox had a much greater impact on hypatatoxicity than lamisil. He also said that lamisil dosed at 500 milligrams a day for seven days once a month rather than daily was a very safe and equally effective and cost effective treatment option. The ID specialist said he only prescribed the oral agents when there was severe underlying disease or the patient was at risk for developing salicylates or osteomylatis. He only

used the oral agents after he had used topical treatments. Contrary to popular belief, the ID specialist felt that topical treatments worked when used diligently and daily.

Thomas Hunt did not consider onychomycosis a disease, but part of the human condition that 40-50% of humans had. Onychomycosis is rarely invasive into the bone. He felt it was absurd that they would consider funding these drugs, because it was rarely medically indicated to use the oral agents. He recognized the invasive fungal infections in immunocompromised patients needed to be treated and sporanox had been approved for that. As a clinician, he refused to use these drugs, although he recognized that many patients wanted treatment for onychomycosis. He favored griseofulvin for the pediatric population.

Chairman Brodsky said griseofulvin would be on the preferred drug list due to it pediatric indications.

Heidi Brainerd said during the public comment period a speaker said there were no drug interactions associated with lamisil, which was incorrect.

Sandy Kapur agreed that onychomycosis was more of a cosmetic indication than a disease state. The September 2002 FDA Guidelines stated emphatically that before treating with an oral agent that culture must be done and received prior to treatment due to the side effects of these drugs.

The committee discussed whether or not any of the agents should be included on the preferred drug list.

David Campana said the DUR Program could do interventions as people are using the oral tablets when the topicals could be used.

Chairman Brodsky said many people went to dermatologist for cosmetic reasons as opposed to life threatening reasons. He felt they should include an agent on the preferred drug list. Dr. Bochacheeka (ph), a dermatologist, felt that lamisil should be included on the preferred drug list.

Thomas Hunt pointed out that they were not reimbursed in an office setting for cosmetic procedures.

Chairman Brodsky said they were not reimbursed for surgical cosmetic procedures as opposed to treatments for dermatological conditions.

David Campana said another option would be to put a prior authorization on the oral medication, which could only be used after trying the topical agents.

Chairman Brodsky said there was no evidence that showed topical agents were effective for onychomycosis.

Sandy Kapur said they had a standard clinical edit that required a lab culture and an underlying disease state before prior authorization was granted for oral agents for onychomycosis.

David Campana suggested placing a preferred drug on the list and then requiring prior authorization separate from the medical justification, lab cultures and determination that it was medically necessary due to an underlying disease.

RONALD MILLER MOVED TO PLACE GRISEOFULVIN ON THE PREFERRED DRUG LIST. SECONDED BY RICHARD REEM. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Hunt, Miller, Reem, Richey, Stables, Stransky, vonHafften, White.

NAY: None.

JANICE STABLES MOVED TO ACCEPT LAMISIL TO THE PREFERRED DRUG LIST TO BE PRESCRIBED, AFTER A LAB CULTURE AND THE DETERMINATION OF AN UNDERLYING DISEASE STATE WAS OBTAINED, WITH PRIOR AUTHORIZATION.

David Campana said prior authorization should be a requirement for both lamisil and sporanox, otherwise sporanox would be available without the prior authorization requirement.

JANICE STABLES AMENDED THE MOTION TO ACCEPT LAMISIL AND SPORANOX TO THE PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION AFTER A LAB CULTURE WAS OBTAIN AND IT WAS DETERMINED THAT THERE WAS AN UNDERLYING DISEASE STATE.

Chairman Brodsky said the committee needed to decide which agent they wanted to include on the preferred drug list for a patient with onychomycosis, a lab test and a co-morbid condition. Then they could attach a prior authorized requirement.

George Stransky said a physician could still prescribe the other medication if griseofulvin did not work by noting medical necessity on the prescription. He felt the motion added unnecessary complications for the practicing physicians.

Chairman Brodsky said the preferred drug list was designed to reduce costs. If they added a drug to the list then it would get thrown in with the batch bidding and the drug cost might be lower. If the drug was not included on the list, they might pay a higher price for it.

In response to Heidi Brainerd's question on how this would work for a community pharmacy, David Campana said prior authorization could be obtained at the pharmacy or at the physician's office.

In response to Terry Babb, Chairman Brodsky said the pharmacy would have to contact the physician's office to obtain the information for the prior authorization at the pharmacy level.

Sherrie Richey felt they needed to decide on the purpose of the P&T Committee. If the purpose of the committee was to force providers to know what the clinical indications for the disease were before they prescribed a drug then that was one thing. If the purpose of the committee was to try to have drugs available at the cheapest cost to the state then that was another thing. All of the drugs that we prescribe have indications and contraindications and we are assuming that the physicians knows these before prescribing the medication. She was not sure that the P&T Committee should be making their decisions based on the assumption that they were going to train the physicians to use what they considered to be the correct drug by creating a preferred drug list. It seemed reasonable to look at efficacy, dosing schedules and side effects and then decide which drug would be better, without all the additional

housekeeping and expensive tasks at the pharmacy level. If we want to use the drug then we should put it on the list. She did not feel the P&T Committee should be training the physicians to use whatever drugs they felt were appropriate by making it difficult to prescribe other drugs.

Chairman Brodsky said they were not trying to teach the physicians the indications for prescribing drugs, but they were trying to train the physicians to use the drugs on the preferred drug list as much as possible.

Terry Babb felt using the prior authorization system was an effective tool. He suggested adding the generics plus one other product to the PDL. The prior authorization process was an avenue they could use to address whether the drugs were appropriately used.

Chairman Brodsky pointed out that the P&T Committee has not dealt with prior authorizations in any of the other classes and he questioned whether or not that was their charge.

David Campana felt it would be easier if they dropped the prior authorization discussion and went ahead with the preferred drug list. The Drug Utilization Review Committee could address prior authorizations in another meeting.

JANICE STABLES WITHDREW HER MOTION.

RONALD MILLER MOVED TO PLACE GRISEOFULVIN AND LAMISIL ON THE PREFERRED DRUG LIST. SECONDED BY ARTHUR HANSEN. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Hunt, Miller, Reem, Richey, Stables, Stransky, vonHafften, White.

NAY: None.

IX. SHORT ACTING BETA-ADRENERGICS (MDI AND NEBS)

Sandy Kapur reviewed the inhaled short-acting beta-2 agonists. The proventil meter dose inhaler is available as a CFC and HFA product. The CFC product is available generically as albuterol. Ventolin is available as a CFC and HFA meter dose inhaler. The CFC product is available generically, but not as the HFA product. Alupent is available brand name only as meter dose inhaler as a CFC product. The CFC product is a chlorofluorocarbon, which depletes the ozone layer. The HFA is a propellant hydrofluoralkane, which does not destroy the ozone layer. According to the Montreal Act, chlorofluorocarbons should have been wiped out by the year 2000, but CFC products are still available and in use. Albuterol is the gold standard in this classification. Our pediatric and pulmonary specialists both agreed that albuterol was the gold standard. They felt that perhaps alupent had a slower efficacy rate than albuterol and they were not proponents of it. They both were emphatic that CFC inhalers had a tendency to freeze due to something inherent to the region and climate of Alaska, but the HFA inhalers maintained their chemical integrity in decreased temperatures or climates. The fourth agent is maxair autohaler and is available brand name only as a dry powder inhaler and is the only breath-actuated device in this class. The specialists felt that the maxair autohaler had very poor and unreliable disposition, because the dry powder sometimes clumps up. They felt that of the CHC inhalers, albuterol

should definitely be on the preferred drug list in a generic formulation and one of the HFA products should also be included due to stability of the product in this region.

In response to Thomas Hunt, Sandy Kapur said the specialists did not mention anything in regards to the taste or the feel of the propellant. They were mostly concerned with the chemical integrity in temperatures below zero.

TERRY BABB MOVED THAT THE TWO ALBUTEROL HFA PRODUCTS WERE EQUIVALENT AND ONE SHOULD BE INCLUDED ON THE PREFERRED DRUG LIST. SECONDED BY THOMAS HUNT. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Hunt, Miller, Reem, Richey, Stables, Stransky, vonHafften, White.

NAY: None.

RONALD MILLER MOVED THAT ALL THE ALBUTEROL CFC PRODUCTS WERE EQUIVALENT AND ONE SHOULD BE INCLUDED ON THE PREFERRED DRUG LIST. SECONDED BY ARTHUR HANSEN.

Richard Reem pointed out that only one of the CFC products had a pediatric labeled for ages 4 and up.

Sandy Kapur said they had the same active ingredient, which was albuterol.

CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Hunt, Miller, Reem, Richey, Stables, Stransky, vonHafften, White.

NAY: None.

X. LONG ACTING BETA ADRENERGICS - INHALED ASTHMATIC DRUGS

Sandy Kapur reviewed the long acting beta adrenergics, serevent diskus and foradil aerolizer. The pediatrician and pulmonologist felt both agents were considered clinically equivalent when used in equal doses, but the device mechanism of delivery of the serevent diskus was more convenient for the general population and would warrant its preference over the foradil aerolizer. Foradil is coming out with a product called foradil certihaler, which will be very similar to the serevent diskus. The foradil certihaler has not been formally approved or launched, but she suggested reviewing the classification once the product came out.

An unidentified female said Owen Hanley, a pulmonologist in Fairbanks, strongly recommended the serevent diskus.

In response to Terry Babb, Sandy Kapur said serevent was no longer available in a meter dose inhaler.

ARTHUR HANSEN MOVED TO ADD THE SEREVENT DISKUS ON THE PREFERRED DRUG LIST. SECONDED BY RONALD MILLER. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Hunt, Miller, Reem, Richey, Stables, Stransky, vonHafften, White.

NAY: None.

Sandy Kapur said due to the SMART study in 2003, new warnings were placed on the product labeling of products containing salmeterol, which included advair and the serevent diskus. The warning stated that patients receiving salmeterol died significantly more often than those patients who were taking a placebo. However, in the sub-analysis of patients that were on inhaled corticosteroids, it appeared that there was not an increase in adverse events. She felt this was something that further expanded on the idea that long acting beta-2s were not a replacement for inhaled corticosteroids.

Sandy Kapur reviewed the short acting beta-2 agonist nebulizer agents. This class has four products, but truly only represents two chemical entities. Alupent is available as a nebulizer solution. Accuneb is a preservative free nebulizer solution of albuterol. Proventil is albuterol, available as a concentrated solution for nebulizers as a unit dose. Xopenex is a racemic albuterol. The pediatrician and pulmonary specialists felt the albuterol products were superior to metaproterenol and the generic albuterol was considered the gold standard. They would prefer that accuneb also be available, because it is a preservative free solution and has a lower concentration of albuterol than the standard nebsulizers. They both agreed that the cost of xopenex was substantially greater than the generic albuterol and should not be preferred, but should be available for patients who had failed regular racemic albuterol. They agreed that some patients could not tolerate albuterol and did very well on xopenex, but they did not foresee the need to have it available for everyone.

JANICE STABLES MOVED TO ADD ACCUNEB TO THE PREFERRED DRUG LIST. SECONDED BY AN UNIDENTIFIED MALE.

In response to George Stransky, Sandy Kapur said the preservatives in the generic albuterol was irritating to some patients and they could not tolerate it.

In response to Terry Babb, Sandy Kapur said less than 1% of the people had an irritating effect in the form of bronchospasm with the preservatives.

CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION FAILED.

Chairman Brodsky noted that the preferred drug list would only include the generic short acting beta-2 agonist nebulizers.

XI. MISCELLANEOUS CONTINUED BUSINESS

Chairman Brodsky returned to the issue of ACE Inhibitors, because the previous meeting minutes indicated that the P&T Committee wanted to review that classification again. Altace and the generics were included on the preferred drug list.

ARTHUR HANSEN MOVED TO INCLUDE THE FULL RECOMMENDATION FOR ACE INHIBITORS TO INCLUDE LOTENSIN, ACEON, MAVIC AND UNIVASC, IN ADDITION TO ALTACE AND THE OTHER GENERIC DRUGS. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED.

AYE: Thirteen unidentified persons.

NAY: Two unidentified persons.

Chairman Brodsky said the public comments and legislative hearings that occurred since the last meeting requested a change to the criteria.

David Campana said the main comment he received from the prescribing community was the need for a fail clause in the criteria. If a patient fails on the preferred drug then the non-preferred drug would be available and the physician would just note that on the prescription. The physician could state on the prescription that the preferred drug was ineffective for the diagnosis or clinical condition. The current criteria states that a physician can prescribe a non-preferred drug by noting on the prescription the medical necessity due to allergy of the preferred drug; contraindication, toxic side effects or drug-drug interactions with the preferred drug; or a special indication for the non-preferred drug.

THOMAS HUNT MOVED THAT THEY ADD TO THE ESTABLISHED CRITERIA THAT A NON-PREFERRED DRUG BE JUSTIFIED BY MENTIONING A FAILURE TO RESPOND TO THE PREFERRED DRUG. SECONDED BY ALEXANDER vonHAFFTEN. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

AYE: Babb, Boothe, Brainerd, Brodsky, Conright, Hampton, Hansen, Hunt, Miller, Reem, Richey, Stables, Stransky, vonHafften, White.

NAY: None.

Alexander vonHafften questioned whether the criteria should say that the patient had to have an allergy to all the medications on the preferred drug list within a classification before a non-preferred drug could be prescribed. The assumption was that the physician would try all the medications on the preferred drug list before prescribing a non-preferred drug. He questioned how that would be documented on the prescription.

Terry Babb felt it was sufficient to have the physician note that the patient had an allergy to the available medications before a non-preferred drug was prescribed.

Arthur Hansen said he would feel sorry for the patient if he had to try all the preferred medications in a classification before a non-preferred medication could be prescribed.

Heidi Brainerd felt it would depend on the class of the drug being prescribed. A patient that had an adverse effect from an SSRI may very well benefit from a different SSRI. She felt the documentation should be a clinical judgment. The allergy information should be filled out as much as possible, because the pharmacists puts that in the patient's medical record and that information could be used later to catch other potential adverse drug reactions.

Chairman Brodsky felt the easiest way to handle the issue would be for the physician to write "allergic reaction" on the prescription.

Sandy Kapur said other states had not implemented a program where the provider could override the system at the pharmacy level. Other states used a prior authorization process through the call center. In most states, First Health has requested that those drugs be placed on the patient's profile or some other clinical documentation be provided. The prior authorization process through a call center has stipulated criteria that the patient must fail two of the preferred agents for a minimum trial period of one or two months specific to the classification. Using the call center provides more control, because they have access to the patient's past claims and all of the pharmacy information.

Terry Babb said if a patient had an allergy then that would create a situation where the preferred drug list was null and void and a physician could use any product. He felt the physician should be able to make prescription determinations without delaying the process of the pharmacy providing the patient with the medication.

Chairman Brodsky agreed that it should be up to the physician and noting an allergy to one of the preferred medications should be sufficient.

Heidi Brainerd said the pharmacist could only function within the clinical information available to them. Specifying the allergy was not that difficult and would allow the pharmacy to code that into the record.

Janice Stables suggested using a five-bullet system to include things such as allergy, failed PDL drug, adverse reaction, interaction and special indications. The committee discussed the possible wording for exceptions.

In response to Janice Stables, Chairman Brodsky said he received a letter from a doctor stating that he believed the committee had made an error by not including the other pegylated interferon classes. For that situation, the physician would simply have to write "special indication" or "adverse reaction" to prescribe a non-preferred drug.

David Campana said a non-preferred drug would be available if the prescriber wrote on the prescription that the drug was medically necessary because the patient either had an allergy, failed therapy, averse reaction, interaction or special indication.

Terry Babb said they needed to decide how the process would work rather than what the physician would write on the prescription.

David Campana said they would provide a letter to the physicians outlining the criteria and how prescriptions should be written.

Terry Babb said he would like to see something written down on paper before he would feel comfortable voting on it.

Chairman Brodsky felt the committee should vote on the criteria. Reviewing each of the letters that went out to the physicians would be a very cumbersome process.

David Campana said two letters were sent out in December. They received a new address list from the Division of Occupational Licensing, so future letters would be more widely distributed. They have a new letter to be mailed out in the near future, which could be reviewed by Chairman Brodsky or the committee could decide to review future letters before they were mailed out.

The committee discussed the development of the criteria and how it would work at the pharmacy level.

Chairman Brodsky said Terry Babb was concerned that this system would be confusing to the pharmacist. Chairman Brodsky was afraid there would be opposition by many physicians to any form of regulating prescriptions to patients. He felt they needed to make it as simple as possible so the physicians would buy into the process.

Sherrie Richey felt they should simply say "failed preferred drug." It did not matter why the patient failed the preferred drug. She felt most of the doctors in Alaska did not want to spend money on things that were unnecessary.

Chairman Brodsky said they could send out a letter outlining the five criteria and if the patient met one of the criteria then the physician could write "failed preferred drug" on the prescription. That would make the system simple and would not be confusing to the pharmacist.

Heidi Brainerd said allergy information was important, because it saved lives, especially when you are in a disconnected system where people go from place to place. The more information you provide to other members in the health care team, the better care the patients will receive. She felt it would be beneficial to have a one word description of what happened with the allergy so the pharmacist could put that into the system.

George Stransky suggested having the physician say "failed preferred drug" and then specify the drug that failed.

Janice Stables did not feel that would cover people who were grandfathered because they had been on the medicines before or people who had not actually failed the medication but the provider felt they needed to be on a different drug.

Alexander vonHafften said they only specifically talked about grandfathering patients using pegylated interferons. His personal preference was to have the letter drafted and then reviewed by the committee before it was sent out.

Chairman Brodsky suggested adding the letter issue to the next meeting's agenda so the letter could be reviewed at the beginning of the next meeting.

Richard Reem felt acronyms should be limited in the letter, because they were confusing. Everything should be spelled out for clarity.

Chairman Brodsky asked that a letter outlining what should be written on prescriptions be drafted before the next meeting so the committee could review it.

In response to Chairman Brodsky, David Campana said the preferred drug list did not address off label FDA indications. (Indiscernible -- away from microphone.)

Chairman Brodsky said off label FDA indications would not be an issue covered by the P&T Committee, but it might be something the DUR Committee would look at.

XII. CLASSES FOR THE NEXT P&T MEETING

David Campana reviewed the classes that would be reviewed at the next meeting: dihydropyridine and non-dihydropyridine calcium channel blockers, inhaled and nebulized corticosteroids, nasal steroids, second- and third-generation quinolones, fibric acide derivatives and statin lipotropics. The group discussed the possible specialists for the next classification to include Dr. Demain and Dr. Dion Roberts. (Indiscernible -- multiple speakers away from the microphone.)

Alexander vonHafften suggested contacting the State Medical Association to see if they could recommend specialists to review the next classification. The committee further discussed the specialists that would be helpful for the next classification.

David Campana said the next meeting would be on March 19, 2004 at the same location in the Frontier Building.

Sandy Kapur reviewed the drugs that had been placed on the preferred drug list.

AN UNIDENTIFIED MALE MOVED TO ADJOURN THE MEETING. SECONDED BY AN UNIDENTIFIED MALE. CHAIRMAN BRODSKY ADJOURNED THE MEETING.

The meeting adjourned at 11:40 a.m.